An unusual patient in a Buddhist family in Sri Lanka

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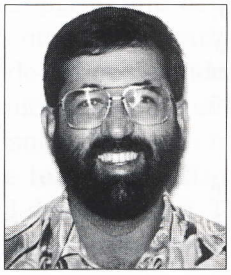

Curriculum Vitae

Frikkie Kellerman qualified from the University of Stellenbosch in 1982. He worked as a rural generalist in Venda (at Tshilidzini Hospital) for 10 years, after which his field of service shifted to Sri Lanka. His main interests and activities focused on the practice of personalised primary health care, the development of clinic and community services, the education of PHC workers, the stimulation of visionary rural health care, and 'the spiritual renovation of medicine'. He is also busy with the MFamMed – course at Medunsa and plans to return to Sri Lanka soon, to assist with the establishment of a Christian Medical Centre in Dehiwela. During the time of this article, he was living in a mountain village for orientation, learning about the country, the language and the people.

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Summary

When Arjuna, my neighbour, bought his latest family member, it led to a personal and professional life-changing experience for me. The one who fell ill and became my patient, was a cow. The story unfolds as I struggle to find my place as a family physician in such a situation. The way the family and community cared for our family-cow-patient was just amazing ... actually better than patients are sometimes cared for in our hospitals. It also bound us all together as one, even in the grave. The story illustrates the importance of relationships, aspects of the Buddhist way of thinking and living, as well as the important role animals can play in a family's life. Family physicians therefore need to see animals (as family members) as their patients too. Death is also looked at in a new way.

Introduction

High up in the Sri Lankan mountains of spice – with their tropical fruits, ever-flowing streams, breathtaking sunsets and blood-sucking leeches – Arjuna bought his latest family member for 9 000 rupees (R600)! It led to an experience that influenced my life and practice deeply.

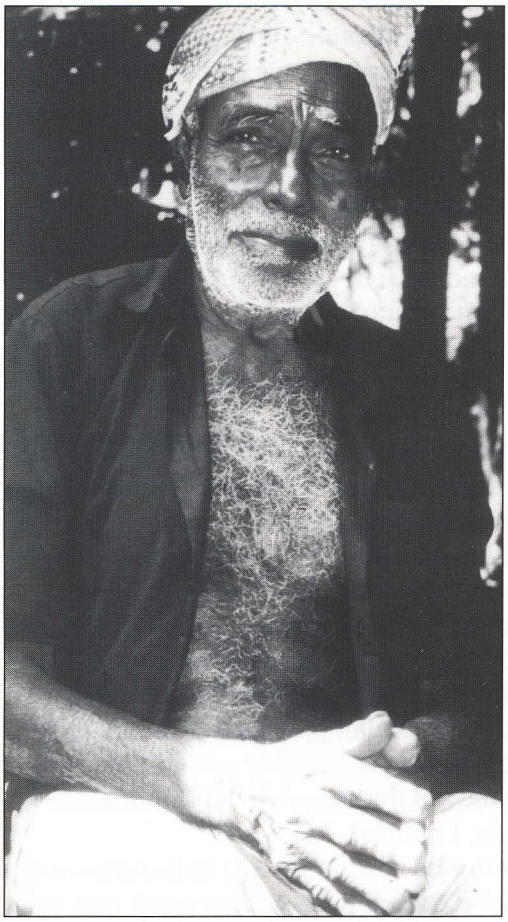
The family

Arjuna owns a brick house in the forest. Opposite it, the picturesque terraces of his neat paddy fields step deeper down into the surrounding forest. The river where we bath and fetch water is just 50 metres from his house.

Every day at sunrise and at sunset he climbs the straight, dangerously high Kittul trees (using his hands and feet

only) to collect syrup for making traditional sweets. We suck it with the delicious local Ceylon tea. He is a skilled craftsman, and though he has little money in the bank, he has precious people in his home. He is very friendly, willing to help where he can, sometimes on time, usually quiet and somewhat insecure. He talks little with his wife, less with his children and more with his friends – with whom he often goes to drink (to his wife's evident dissatisfaction). It also seems that failure to discipline his teenage son, Sanath, occasionally causes friction between him and her.

Sanath was my first patient on the island. Being quietly independent, he refused to continue schooling. He doesn't give much attention to his sisters, but likes to be with the 'boys' in the village and at the temple, which is just a few hundred metres from our home. Nearly all the people in the village are Buddhists.



Arjuna – who talks little with his wife, less with his children, and more with his friends.

Karuna, a 14-year-old girl, with thick black hair flowing low down her back, is her mother's dream child. She's very homely, friendly, but shy. While girls of her age seem closer to their fathers (especially in Sri Lanka), she's more distanced from him. I never saw them in conversation with one another.

Kusum (12 years old) is the 'tom-boy'. Her hair is kept short. She enjoys playing with younger children, but loses her temper easily. When visitors arrive, she quickly withdraws to her room or scarcely says a word.

Rural family physicians should know more about veterinary diseases.

The youngest, Padmini (meaning the lotus-like one) is a jewel in the family. She's always happy and playful, close to her mother and sisters, but not so to her father and brother. I'll never forget the picture of Padmini in her pink dress, kneeling at their fishpond with the pink water lily blooming in front of her, the evergreen forest behind her, and the altar for their household gods and Buddhist deities next to her. With her big, bright, eager, dark eyes, she looked as innocent and pure as the lotus flower – the Buddhist symbol of enlightenment.

Shila, the mother, is really the pillar of the family. In her humble way of serving and caring, with her sometimes surprisingly innocent naturalness in relating, she is one of the most exemplary neighbours I've ever had.

I tried to understand the context of the illness.

Our patient's story

Just a few days after Arjuna bought his youngest 'daughter' (a cow), I was called to see her. She was not eating and appeared weak. She had no diarrhoea or vomiting. On examining her, I noticed she was underweight and felt febrile. Her breathing, abdomen, nose and salivation were normal. A few weeks earlier, Arjuna's dog, Lucky, also became ill, was put under my care, got treatment and became well (much to my own relief), though I didn't think it was due to the medicine. This time I felt I could not take responsibility for the treatment, but I realised I could still function

responsibly as a family physician in exhibiting, according to McWhinney[1] "an interest in (my) patient (the cow) that transcends the illness she suffers from", as well as seeking "to understand the context of the illness", and actively seeing myself "as part of a community-wide network of supportive and health-care agencies", while being sensitive to the feelings of all involved and looking for insight into the dynamics of the relationships within and without this family. I also saw that a "physician is responsible for ensuring continuity of service by a competent deputy and for following through when some aspect of care is delegated to a consultant". This is what I then tried to do.

The veterinary assistant from a village down the mountain was called. He diagnosed pneumonia (in the absence of tachypnoea) and started treatment. Her condition deteriorated. We then found the veterinary surgeon, who came out at a high cost to Arjuna. He thought she had eaten poison and injected her with Atropine. Discussing their diagnoses with them did not take away the doubts I had – in my unfortunate ignorance about veterinary diseases.

I waited ... The family cared ...!

Arjuna built a nice shed for her, just next to the house. The rich muddy Sri Lankan soil was covered with sawdust for her to sleep on. All his daughters and Shila worked as one. They made a wall for the shed from dry palm leaves (beautifully folded and tied together). It was beautiful to see them all working together like this. Arjuna and Sanath regularly cut fresh grass and special leaves – together – even late at night, using a lamp or torch. By now our patient was mostly lying on her side, which seemed desperately late to me. They covered her with plastic bags or material for a blanket and fed her by hand. Medicinal leaves were burnt in coconut shells for treating her rigors.

I can see it all again: Arjuna putting fresh, dry sawdust under her, positioning her legs comfortably, then sponging them conscientiously, with anxious concentration and deep furrows between his eyebrows... while Shila lovingly puts a piece of cloth under her head, caressing it and her neck quietly... then gently removing thick mucous from her mouth and nose, and slowly wiping it clean.

I wondered if they were only treating their 'patient', or also their pain, or maybe their marriage or their future. Whatever it was, **it was touching.**

The doctor as part of the wide network of support and health care agencies.

She seemed to be dying...

Sanath and his friend arrived and secretly buried a lemon and soil from the temple at each corner pole of the shed, carefully following their priest's instructions. One or two hours later she was much better and even stood up!

We rejoiced, but soon she was worse again. The veterinary surgeon and assistant came again and started treatment for tickbite fever. She had no fever. Her crop got swollen and she weakened. They then thought that she had swallowed a foreign body. By now, I was at a total loss. What was the correct diagnosis? Was there still hope? "What-to-do-man?" (as the Sri Lankans very typically sing-say). Arjuna also had no money left to pay for the call-outs... but he had neighbours.

The GP is responsible for continuity even when a consultant is called.

I think the whole village must have known about her illness. Many came, advised and talked (even 'til midnight) in the warmer kitchen or around her, sometimes with monsoon rains pouring down around us. At one stage someone suggested a certain treatment for the bloating. This was ceremoniously administered by one, while another held her horns, another her head, with Shila constantly speaking soothing words to her, stroking her softly. One day, as they covered her with two blankets, I noticed a neighbour gently positioning her ear out over the blankets, just to be caringly advised by Shila rather to cover it again.

Questions shot deep into my mind and heart: Do we care like this for our human patients? Do we care?

Some of the carers shared one night in the kitchen how good it could be if we would also care for our children so constantly and maximally... Shila emphasised it heartily, while looking at her husband. He just sat quietly, a little bent.

It seemed we all had a share in caring, we all related to each other in this suffering, we were all involved..., but most beautiful to me was **Arjuna's family: now a unit**, drawn together in one purpose, one task, the task of caring for their suffering family member.

CARING INTENSIFIED

The next day chairs were constructed around our cow patient. An old Tamil man (who was sadly enough, racially despised by Arjuna's beautiful old Singalese mother) was hired to serve as a 24-hour nurse to the patient. He sat and slept next to her – day and night – for nearly two full weeks! Despite this sacrifice, it was so sad to see that though the love for a cow could bring a family and neighbours together, it could not do so where racial hatred still ruled a heart. **A stronger love**[2] is needed for that and for ending the tragic ethnic war that has been raging for the last 14 years on this island, the 'pearl of the East"[3] that had become 'an island of tears'.[4]

The next day she could stand with support and ate eagerly. We were all happy! The children were running around and played joyfully. Shila, definitely strained by the crisis and the many visits (by now she had a near-empty kitchen), was amazingly relaxed, smiling and happy too. The neighbours kept coming..., talking, looking, laughing, lingering, lovingly touching our patient ... **all being one:...community through crisis.**[5]

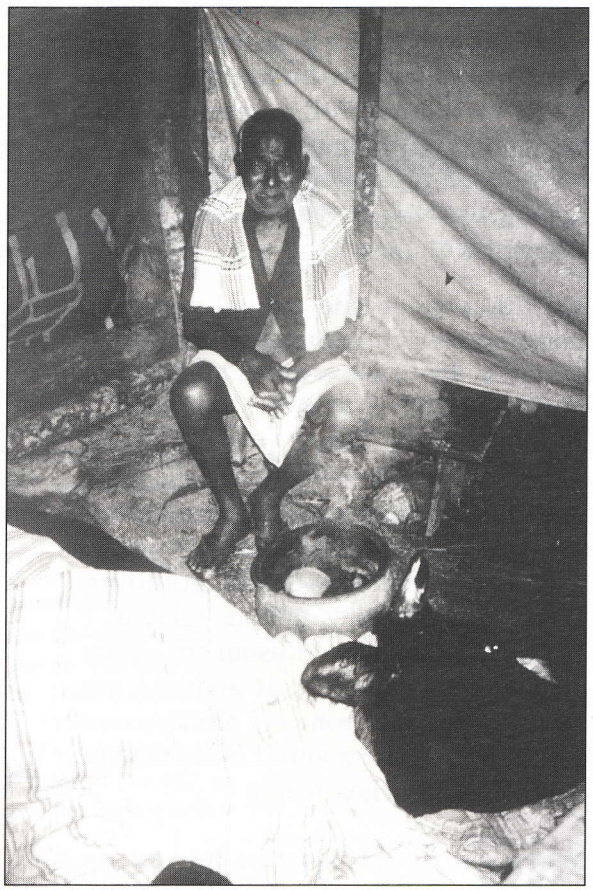
I was amazed at the family's perseverance and desperate self-sacrificial service to especially a member of the family, who we, in the western world, would mostly not even consider to be part of the family.

A few days later she got worse again, lying on her side only and unable to turn herself or to stand up. With no small effort (for such a big patient) she'd be turned a few times every day, in an effort to prevent 'bedsores' from developing! A powder was also applied at pressure points to further help prevent it, and as if that was not enough, she was also put in a hammock-type traction once or twice a day!

It seemed we all had a share in the caring.

The whole procedure of getting her up, 'standing' or rather hanging in her hammock/traction, would take nearly an hour. It could only be done through a joint effort, mixed with intense emotions, eager suggestions, willing hands and constant orchestration... I'll never forget it. We'd be six or eight men: talking, planning, suggesting, pulling, shouting, groaning (under her weight), sweating, replanning, failing, changing, differing, listening, trying... and succeeding... **together.** Shila too was always present, to do what she could, calm our patient, give the motherly touch, with ample suggestions too. The not-to-be-forgotten blended smell of our patient, the smoke from the burning leaves, the occasional alcohol breaths, sweat, and soup from the nearby kitchen seemed to me much more 'holistic' and medicinal than those in our modern-day impersonal hospitals. Added to this was the feeling of mud and cow dung squirting between

Community through crisis.



Our patient and the nurse.

your toes! All for a purpose, a common goal.

By now, Arjuna appeared to be a relieved man. Much of the tension in his face and ways were gone. It may be that he has 'proven' his faithful caring, or that he too was aware of this new sense of 'community' and of 'family'.

A few days later I was anxiously called to come for help. She was hanging very limp in her hammock/traction. They wanted to let her lie down. Coming close I saw that her eyes were glassy, cold, without life. I thought they must have seen it themselves and didn't want to talk about it, so I kept silent and with a wound in me, continued to help them in caringly bringing her down to her 'bed'. Only then was it recognised that she had passed away. Arjuna appeared stunned and trembled visibly, while tears moistened his eyes. Shila sobbed out her grief through red eyes. Her cheeks were wet with tears as she leaned against a corner pole of the shed (this time with our patient between her and Arjuna). Then squatting next to her, she bent over her and gently stroked her head, cheek and neck in a heartfelt greeting. She cleaned her mouth, covered her sores and closed her eyelids lovingly. Now Arjuna was next to Shila and I was just there ... with them.

As if they were told, neighbours and children started arriving within a few minutes. We drank tea and ate 'roti' (a thick firm pancake). Next to the shed, a few metres further down the steep muddy slope, between the tropical trees and plants, we started digging a big grave, using traditional hoes. Women, men and children were all standing around us; watching, talking, relating. I saw Shila, Pamini and Kusum cry – each on her own (again?). It gripped my heart. To see someone cry alone is one thing, but to see a small child crying alone really touches deeply.

Were we burying what bound us together, or were we fertilising the soil for a new life (a new family life) springing up..., or were some of us labouring to close their own graves of reincarnation with spades of 'karma'?

Whatever it was, even **in** the grave, digging deep, we were **one.**

With the tropical sun beaming through the thick, green forest leaves, warming the wet soil and lightening the darkness in the shed, we carefully, but with great difficulty, pulled her down the slope and into the grave, holding her head protectively along the way.

Around the covered grave, we were still **one.**

Then, on this day that we parted with our patient and relative, and only then, did Shila start making my 'sarong' – the traditional 'skirt' – worn by Sri Lankan men!

Relationships are important in the practice of medicine.

MY LEARNING

I learned a great amount from this extraordinary experience. Much can be said and discussed about it, but I'll leave my reader to his or her own thoughts and conclusions, apart from a few very brief words on my learning.

I learned deeply that **relationships are of paramount importance** in the practice of medicine. This includes my relationship to my patient, his or her disease, the family, the community, the culture and myself.

We all related to one another in this suffering.

I learned that **animals are also family members.** They can play an important role in influencing family life and health, as well as in revealing family function, health or disease, when members' interaction with them are carefully observed. I need to therefore consciously include family animals (and the interactions with them) in my assessment of both the family and the patient, obviously in an appropriate manner.

I further realised that a rural family physician needs to know more about

veterinary diseases, as it sometimes happens that **animals become our patients too.** I should not shun from it, but rather endeavour to learn more, to be able to help better (especially where no veterinary surgeon is available).

It is also very clear that a thorough **understanding of Buddhism** (and the Buddhist way of thinking and living, which can unfortunately not be further discussed in this article) is crucial in becoming an effective, truly helpful family physician in Sri Lanka. Much of what has been described in this patient's story may be well explained within this context.

I further learned profoundly that if the death of a family cow could bring people so near to each other, how much more can people be drawn nearer to each other (across all man made boundaries) through the death and resurrection of the **One** who made both the cow and us, **Jesus Christ.**[6,7]

I wish to thank Arjuna, his family and neighbours heartily for making me part of their lives and this experience too.

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News

JUNE 1996

GENERAL

MRC signs agreement with northern Cape government

A historical collaborative agreement between the Medical Research Council (MRC) and the Northern Cape Province (NC), to improve health conditions in the province, was signed in Kimberly recently.

The agreement, the first of its kind, falls under the umbrella of the Regional Institutional Support Management Committee (RISMAC), which is a representative body of the eight science councils in South Africa.

RISMAC was formed to provide a 'one-stop technology shop' to the Premier's Office for all activities related to the core business of its constituent members, which include the CSIR, MINTEK and the National Parks Board. It aims to establish an effective working relationship with and delivery services to the government of the Northern Cape.

Under the terms of the agreement the MRC will set up an office in Kimberly and will provide the NC Department of Health with the following: capacity building, especially in respect of research skills, staff support and organisational development, and short-term research in key areas of health service delivery.

"It is our task as leaders to uplift the conditions under which the people of the Northern Cape live. By means of this agreement between the MRC and the NC we will be able to seek scientific solutions for our health problems.

This partnership between us will prove to our people, who live under harsh, basically rural conditions, that we can do something to improve their quality of life," said Manne Dipico, Premier of the NC, at the signing of the agreement.

"It is a privilege for the MRC to enter into this joint venture with a provincial government. Together we can achieve real growth and development in the health sector in the area and so benefit the people both in the short and the long term."

The Northern Cape is a very important area, showing a unique combination of needs and opportunity which set a unique set of questions for our researchers to solve. We are awaiting the results with great expectation," said Dr OW Prozesky, President of the MRC.

For further enquiries contact: Dr OW Prozesky/Ms Merle May (MRC), Tel: (021) 938-0240/1.